DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: U T — 0 1 - 020

2. STATE: UTAH

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~July 1, 2001~~ October 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 435.914

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ ~~0~~ <2,216,340>
b. FFY 2002 $ ~~0~~ <2,216,340>

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATTACHMENT 2.6-A, Page 24

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
Effective Date of Eligibility

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF ~~STATE AGENCY OFFICIAL~~:
Rod Betit

13. TYPED NAME:
Rod L. Betit

14. TITLE:
Executive Director
Department of Health

15. DATE SUBMITTED:
September 17, 2001

16. RETURN TO:
Rod L. Betit, Executive Director
Department of Health
Box 143102
Salt Lake City, UT 84114-3102

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
October 18, 2001

18. DATE APPROVED:
November 20, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:
Spencer K. Ericson

21. TYPED NAME:
Spencer K. Ericson

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: October 11, 2001

FORM HCFA-179 (07-92)

Instructions on Back

Citation	Condition or Requirement

42 CFR 435.914

11. Effective Date of Eligibility

a. Groups Other Than Qualified Medicare Beneficiaries

(1) For the prospective period.

Coverage is available for the full month if the following individuals are eligible at any time during the month.

__X__ Aged, blind, disabled.
__X__ AFDC-related.

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

_____ Aged, blind, disabled.
_____ AFDC-related.

(2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied.

__X__ Aged, blind, disabled.
__X__ AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied.

_____ Aged, blind, disabled.
_____ AFDC-related.